NAVAL MEDICAL CENTER SAN DIEGO
THE PRIDE OF NAVY MEDICINE

BARIATRIC PROGRAM

PATIENT HISTORY QUESTIONNAIRE
(Please Print)

PERSONAL INFORMATION

Name: _____Date: _____

Sponsor's SSN# _____-_____-_____ Date of Birth: _____ Age: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Mobile Phone: _____ Home Phone: _____

Work Phone: _____ Email Address: _____

Marital Status: Single Married Divorced Widowed **Gender:** Male Female

Occupation: _____ How many hours a week do you work? _____

Number of Children: _____ Ages of Children: _____

Do you care for elder relatives? _____Who_____What is your involvement in the care? _____

Who lives with you? _____

How long have you been considering bariatric surgery? _____

Have you done any research regarding bariatric surgery? _____

If YES, what type _____

How did you hear about this program? _____

Do you have a friend or family member who has had Bariatric Surgery?_____Who? _____

Primary Language Spoken _____ Primary Language Reading _____

***PLEASE DO NOT COMPLETE THIS SECTION**COMPLETED BY SURGEON AT TIME OF APPOINTMENT*

HEIGHT	WEIGHT	IDEAL BODY WEIGHT	EXCESS BODY WEIGHT	BMI

BODY FRAME: Small Medium Large Waist: _____INCHES Hip: _____ INCHES

B/P _____ P _____ R _____ Neck circumference _____ INCHES

NAME:	SPONSOR'S SSN#:	DOB:

PERSONAL MEDICAL HISTORY: Do you have or have you ever had any of the following. Check all that apply.

CARDIOVASCULAR	YES	NO	Do Not Know	GASTROINTESTINAL	YES	NO	Do Not Know
Heart Disease				Do you experience heartburn or reflux?			
MI (Heart Attack)				How many times per week?			
Abnormal EKG				Do you take anti-reflux medications?			
Have you ever had a Stress Test?				**URINARY**			
Have you ever had an echocardiogram?				Difficulty with urination?			
High Blood Pressure				Frequent Bladder infections?			
High Cholesterol				Stress Incontinence?			
Do your legs or ankles swell easily?				Kidney disease or stones?			
List reason for stress test/echo:				**GYNECOLOGICAL**			
ENDOCRINE				Last menstrual period:			
Do you have Diabetes?				Number of pregnancies:			
Average daily blood sugars:				Number of birth(s):			
Do you take oral medications?				Last mammogram: Date:			
Do you use Insulin or Pump?				Was it normal?			
Do you have Hypothyroidism?				Last PAP Exam: Date:			
Do you have Hyperthyroidism?				Was it normal or abnormal?			
				Are you taking hormones? (Birth control or Hormone Therapy)			
RESPIRATORY				**HEMATOLOGICAL**			
Do you have COPD?				Do you have a bleeding abnormality?			
Do you have Asthma?				If so, describe:			
Do you take oral medications or inhalers for Asthma?				Have you ever had a blood transfusion?			
Do you have shortness of breath?				If so, reason:			
How far can you walk before feeling short of breath?				History of blood clots? DVT or Pulmonary Embolism			
Do you currently smoke?				Date & Treatment:			
If yes, how much per day?				Family history of DVT?			
Do you have Obstructive Sleep Apnea?				**MUSCULOSKELETAL**			
Do you use a C-PAP or Bi-PAP device?				Low Back or Hip Pain?			
PSYCHOLOGICAL				Knee, Ankle or Foot Pain?			
Depression				Which side? Right or Left or Both			
Panic Attacks				Have you seen an Orthopedic Surgeon for any of the above conditions?			
Anxiety				Have you had surgery for any of the above conditions?			
Bi-polar Disease				Is orthopedic surgery pending weight loss?			
Obsessive Compulsive Disorder				**INFECTIOUS DISEASES**			
Currently seeking Mental Health				HIV/AIDS exposure?			
Therapy?				Hepatitis			

NAME:	SPONSOR'S SSN#:	DOB:

LIST CURRENT AND PAST MEDICAL HISTORY:

DATE	MEDICAL DIAGNOSIS

LIST PAST SURGICAL HISTORY:

DATE	TYPE OF SURGERY

LIST ANY HOSPITALIZATIONS:

DATE	ILLNESS	TREATMENT

NAME:	SPONSOR'S SSN#:	DOB:

LIST ALL PRESCRIPTION MEDICATIONS:

MEDICATION	DOSE	FREQUENCY

LIST ALL NON-PRESCRIPTION MEDICATIONS:

MEDICATION	DOSE	FREQUENCY

ALLERGIES:

Allergies to any Medications: Yes No
Allergies to any Foods: Yes No
Allergic to Latex: Yes No
List allergies: _____

Surgical tape: Yes No Type: _____

Steri-Strips: Yes No **DermaBond Glue**: Yes No **Iodine**: Yes No

NAME:	SPONSOR'S SSN#:	DOB:

DIETING HISTORY:

Age you first started dieting: _____Approximate weight at age 18: _____Weight before pregnancy: _____

Height: _____ Current Weight: _____ Weight range last 5 years: _____to _____

PROGRAM	YES	NO	DATE(S)	DURATION	MAX LOSS	MD SUPERVISED?
ATKINS						
ALLI						
FEN/PHEN or REDUX						
JENNY CRAIG						
MERIDIA						
NUTRI-SYSTEMS						
OPTI-FAST or MEDI FAST						
SOUTH BEACH DIET						
WEIGHT WATCHERS						
XENICAL						
OVER THE COUNTER DIET AIDS						
Other:						
Other:						

What was the most successful weight loss you have achieved and how did you do it? _____

What behaviors did you learn from dieting that you still use today? _____

_____

FOOD PREFERENCES: **PLEASE COMPLETE A THREE DAY DIARY ON SEPARATE SHEET OF PAPER!!!**

Do you eat sweet and sugary foods? Yes No If so, what? _____

How often? _____

Do you eat carbohydrates, pasta and breads regularly? Yes No If so, what? _____

How often? _____

Do most of your meals consist of fast foods? Yes No If so, what? _____

How often? _____

Do you snack between meals? Yes No If so, what? _____

How often? _____

Is snacking from habit? ☐ Yes☐ No Depression? ☐Yes ☐No Boredom? ☐Yes ☐ No Do you binge eat? ☐ Yes ☐ No

How often? _____

What types and quantity of beverages including Energy drinks do you consume throughout the day? _____

_____

NAME:	SPONSOR'S SSN#:	DOB:

SOCIAL/FAMILY HISTORY:

Is there Obesity in your family? Yes No Who: _____

Are there any medical illnesses in your family? Yes No If so, what: Diabetes Hypertension Coronary Artery Disease

Other _____

Do you exercise regularly? Yes No If yes, what do you do? _____

Do you have any physical restrictions that keep you from exercising? ☐ Yes ☐ No Explain? _____

_____

SMOKING/ALCOHOL/DRUG HISTORY:

Do you smoke now? Yes No **Have you ever smoked cigarettes/cigars? Yes No**

If yes, how much did you smoke per day? _____ **If yes, when did you quit? _____**

Did you drink alcohol? Yes No What type of alcohol do you consume? _____

Do you drink more than 5 drinks per week? Yes No **Less than 5 drinks per week? Yes No**

Have you or are you currently using any recreational/illegal drugs? Yes No

Explain: _____

Do you have a history of abuse? (Please indicate emotional, physical, mental, substance or other types of abuse issues you've dealt with. This information is extremely important and very confidential. Honesty is needed in order to provide you with the best possible treatment plan):

_____

_____

_____

Describe your present life stressors: _____

_____

_____

Describe the present support system you rely on. (Church, spouse, family, friends, co-workers, etc): _____

_____

_____

What is your greatest fear regarding potential surgery? _____

_____

_____

NAME:	SPONSOR'S SSN#:	DOB:

What is your greatest hope regarding Bariatric surgery? _____

_____

_____

_____

What are your goals regarding Bariatric surgery? _____

_____

_____

_____

_____

_____

_____

_____

_____

What is motivating you to seek this type of intervention for weight control and/or loss? _____

_____

_____

_____

_____

_____

_____

NAME:	SPONSOR'S SSN#:	DOB:

PLEASE LIST ALL YOUR CURRENT MEDICAL PROVIDERS:

SPECIALTY	NAME of PROVIDER	ADDRESS or EMAIL ADDRESS	PHONE & FAX NUMBERS
PRIMARY CARE/ INTERNAL MEDICINE			
CARDIOLOGIST			
PULMONARY SPECIALIST			
ENDOCRINOLOGIST			
PSYCHOLOGIST/ PSYCHIATRIST			
ORTHOPEDIC SURGEON			
OB/GYN			

Signature: _____Date: _____

PLEASE HAVE QUESTIONNAIRE COMPLETED AT THE TIME OF YOUR BARIATRIC CONSULT APPOINTMENT AT THE GENERAL SURGERY CLINIC BLDG. 3, DECK 4. CALL CLINIC FRONT DESK FOR QUESTIONS: 619-532-7576

Please note that your information will not be reviewed if this form is incomplete at time of your appointment!

NAME:	SPONSOR'S SSN#:	DOB: